

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5509
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05500

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle William Last BAILEY		4. DATE OF DEATH Month May Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 2 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forman Public Works		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rodney Ellsworth Bailey		14. MOTHER'S MAIDEN NAME Lillie Ridge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1919 - 1925 577-12-5627	
17. INFORMANT Mrs. Maud Bailey - #30 Circla Ave, Potomac Hgts.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolic to brain DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes			
19. INTERVAL BETWEEN ONSET AND DEATH 2 hrs 4 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19 —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1st 1961 to 29 May 1961 , that (I) (we) last saw the deceased alive on 29 May 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE Arthur O. Woody M.D.		22b. DATE SIGNED 30 May 61	
22c. PHYSICIAN'S NAME (Type) ARTHUR O. WOODY		22d. ADDRESS JACWOOD CLINIC LA PLATA, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/1961	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc.		25a. REC'D BY REGISTRAR DATE JUN 2 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1911

REPORT OF THE SECRETARY

(1)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5510 CERTIFICATE OF DEATH 05501											
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MD. b. COUNTY CHARLES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENEDICT				c. LENGTH OF STAY IN 1b 21 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENEDICT				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —						d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) First Middle Last BERNICE P. BOWEN						4. DATE OF DEATH Month Day Year MAY 10 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 26, 1886 74 yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY STATE INSPECTOR CALVERT CO., MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME QUILLA G. BOWEN						14. MOTHER'S MAIDEN NAME MARY ELLEN DENTON					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address AGNES CHING BOWEN - BENEDICT, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Meningeal 443X DUE TO (b) Acute Alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Hypertensive C.V. disease										INTERVAL BETWEEN ONSET AND DEATH 4 days 2 weeks ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF ASCENDING COLON											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.											
22a. SIGNATURE Page C. Jett						M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/14/61	
22c. PHYSICIAN'S NAME (Type) PAGE C. JETT						22d. ADDRESS PRINCE FREDERICK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 12, 1961		23c. NAME OF CEMETERY OR CREMATORIUM SOLOMONS CATHOLIC				23d. LOCATION (City, town or county) (State) SOLOMONS - CALVERT CO. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE A. G. Harkness & Son - Mutual, Md.						ADDRESS —		25a. REC'D BY REGISTRAR DATE MAY 12 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

(M)

Charles

Director

at New York

George F. Jones

at New York

Director of the Bureau

of the Census

Washington, D.C.

(1)

Enclosed for the Bureau are three copies of the report of the Census of the United States, 1900, for the State of New York, and one copy of the report of the Census of the United States, 1900, for the State of New York, and one copy of the report of the Census of the United States, 1900, for the State of New York.

1
FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MAY 1961									
MAY 1961									
MAY 1961									
1. PLACE OF DEATH a. COUNTY <i>Charles</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hogah</i>					c. LENGTH OF STAY in lb <i>1</i>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bisgah (Rural)</i>					d. STREET ADDRESS <i>1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>RONNIE S. BOWMAN</i>					4. DATE OF DEATH Month <i>5</i> Day <i>18</i> Year <i>1961</i>				
5. SEX <i>M</i>					6. COLOR OR RACE <i>C</i>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>5-2-61</i>				
9. AGE (In years last birthday) <i>16</i>					IF UNDER 1 YEAR Months <i>16</i> Days <i>16</i>				
IF UNDER 24 HRS. Hours <i>16</i> Min. <i>16</i>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>				
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Ulysses Bowman</i>					14. MOTHER'S MAIDEN NAME <i>Irene Proctor</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>None</i>				
17. INFORMANT <i>Irene Proctor - Bisgah, Md.</i>					Address <i>5-19-61</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatitis</i> 583X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>INTERVIEW BETWEEN ONSET AND DEATH</i> DUE TO (c) <i>5-19-61</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>E. J. Edelen</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <i>5-19-61</i>				
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>					22b. DATE THEREOF <i>5/19/61</i>				
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Baptist</i>					22d. LOCATION (City, town, or country) (State) <i>Hill Top, Maryland</i>				
23. FUNERAL DIRECTOR <i>Archard Funeral Home, Inc. Lablady</i>					24a. REC'D BY REGISTRAR <i>MAY 26 '61</i>				
ADDRESS					24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

4000295 XV3

80208

WESTLAND STATE DEPARTMENT OF HEALTH
LABORATORY AND CLINICAL DIVISION
311 MEDICAL PLAZA 1ST FLOOR
SAN FRANCISCO 11, CALIF.

100-111111
100-111111

100-111111

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05503

5512

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY MASON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WALDORF		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maysville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS SEX-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NEWTON Middle McMILLIAN Last BROTHERS				4. DATE OF DEATH Month MAY Day 12 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 MARCH 1894	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY TOBACCO		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William BROTHERS				14. MOTHER'S MAIDEN NAME MATTIE VAUGHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Maurice Brothers, 464 West Second St. Maysville, Kentucky			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 4204 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency. DUE TO (c) 10 years							INTERVAL BETWEEN ONSET AND DEATH 1 minute
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. EDELEN				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. EDELEN				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-61		22c. NAME OF CEMETERY OR CREMATORY Carlisle Cem.		22d. LOCATION (City, town, or county) (State) Carlisle, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.				24a. REC'D BY REGISTRAR DATE MAY 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ANY AND STATE OF DEPARTMENT OF HEALTH - BALTIMORE 18

1950

<p>1. Name of Deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of Birth: _____</p>	
<p>5. Place of Birth: _____</p>		<p>6. Usual Residence: _____</p>	
<p>7. Cause of Death: _____</p>		<p>8. Manner of Death: _____</p>	
<p>9. Signature of Medical Examiner: _____</p>		<p>10. Signature of Coroner: _____</p>	
<p>11. Date of Death: _____</p>		<p>12. Time of Death: _____</p>	
<p>13. Place of Death: _____</p>		<p>14. Name of Hospital: _____</p>	
<p>15. Name of Physician: _____</p>		<p>16. Name of Nurse: _____</p>	
<p>17. Name of Undertaker: _____</p>		<p>18. Name of Burial Place: _____</p>	
<p>19. Name of Funeral Home: _____</p>		<p>20. Name of Cemetery: _____</p>	
<p>21. Name of Interment: _____</p>		<p>22. Name of Grave: _____</p>	
<p>23. Name of Monument: _____</p>		<p>24. Name of Marker: _____</p>	
<p>25. Name of Vault: _____</p>		<p>26. Name of Crypt: _____</p>	
<p>27. Name of Urn: _____</p>		<p>28. Name of Casket: _____</p>	
<p>29. Name of Coffin: _____</p>		<p>30. Name of Shroud: _____</p>	
<p>31. Name of Burial Cloth: _____</p>		<p>32. Name of Burial Shroud: _____</p>	
<p>33. Name of Burial Garment: _____</p>		<p>34. Name of Burial Headband: _____</p>	
<p>35. Name of Burial Sash: _____</p>		<p>36. Name of Burial Garter: _____</p>	
<p>37. Name of Burial Stocking: _____</p>		<p>38. Name of Burial Shoe: _____</p>	
<p>39. Name of Burial Hat: _____</p>		<p>40. Name of Burial Glove: _____</p>	
<p>41. Name of Burial Ring: _____</p>		<p>42. Name of Burial Earring: _____</p>	
<p>43. Name of Burial Necklace: _____</p>		<p>44. Name of Burial Bracelet: _____</p>	
<p>45. Name of Burial Watch: _____</p>		<p>46. Name of Burial Pocket Watch: _____</p>	
<p>47. Name of Burial Key: _____</p>		<p>48. Name of Burial Coin: _____</p>	
<p>49. Name of Burial Token: _____</p>		<p>50. Name of Burial Seal: _____</p>	
<p>51. Name of Burial Stamp: _____</p>		<p>52. Name of Burial Mark: _____</p>	
<p>53. Name of Burial Sign: _____</p>		<p>54. Name of Burial Symbol: _____</p>	
<p>55. Name of Burial Emblem: _____</p>		<p>56. Name of Burial Device: _____</p>	
<p>57. Name of Burial Ornament: _____</p>		<p>58. Name of Burial Decoration: _____</p>	
<p>59. Name of Burial Accessory: _____</p>		<p>60. Name of Burial Article: _____</p>	
<p>61. Name of Burial Object: _____</p>		<p>62. Name of Burial Thing: _____</p>	
<p>63. Name of Burial Item: _____</p>		<p>64. Name of Burial Piece: _____</p>	
<p>65. Name of Burial Part: _____</p>		<p>66. Name of Burial Section: _____</p>	
<p>67. Name of Burial Portion: _____</p>		<p>68. Name of Burial Fraction: _____</p>	
<p>69. Name of Burial Element: _____</p>		<p>70. Name of Burial Component: _____</p>	
<p>71. Name of Burial Detail: _____</p>		<p>72. Name of Burial Feature: _____</p>	
<p>73. Name of Burial Characteristic: _____</p>		<p>74. Name of Burial Quality: _____</p>	
<p>75. Name of Burial Attribute: _____</p>		<p>76. Name of Burial Property: _____</p>	
<p>77. Name of Burial Quality: _____</p>		<p>78. Name of Burial Quantity: _____</p>	
<p>79. Name of Burial Measure: _____</p>		<p>80. Name of Burial Dimension: _____</p>	
<p>81. Name of Burial Extent: _____</p>		<p>82. Name of Burial Degree: _____</p>	
<p>83. Name of Burial Level: _____</p>		<p>84. Name of Burial Rank: _____</p>	
<p>85. Name of Burial Grade: _____</p>		<p>86. Name of Burial Class: _____</p>	
<p>87. Name of Burial Order: _____</p>		<p>88. Name of Burial Status: _____</p>	
<p>89. Name of Burial Position: _____</p>		<p>90. Name of Burial Location: _____</p>	
<p>91. Name of Burial Place: _____</p>		<p>92. Name of Burial Site: _____</p>	
<p>93. Name of Burial Area: _____</p>		<p>94. Name of Burial Region: _____</p>	
<p>95. Name of Burial Zone: _____</p>		<p>96. Name of Burial Territory: _____</p>	
<p>97. Name of Burial Domain: _____</p>		<p>98. Name of Burial Kingdom: _____</p>	
<p>99. Name of Burial Empire: _____</p>		<p>100. Name of Burial World: _____</p>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5513

65504

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b Issue d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First Bessie Elizabeth Middle Colbert Last 4. DATE OF DEATH Month May Day 29 Year 1961		5. SEX F. 6. COLOR OR RACE negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH April 16 1906 9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas A. Slye		14. MOTHER'S MAIDEN NAME Elizabeth Milton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT James C. Colbert, Issue, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444X DUE TO Artemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) essential hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-15 19 61 to 5-29 19 61 , that (I) (we) last saw the deceased alive on 5-28 19 61 , and that death occurred at 10 AM , from the causes and on the date stated above.			
22a. SIGNATURE Frédrick M. Johnson M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-30-61	
22c. PHYSICIAN'S NAME (Type) Frédrick M. Johnson MD		22d. ADDRESS La Plata, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF June 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY Holy Ghost		23d. LOCATION (City, town, or county) (State) Issue, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home ADDRESS Waldorf, Md.		25a. REC'D BY REGISTRAR JUN 5 '61 25b. REGISTRAR'S SIGNATURE Arthur S. K...	

14

R/C

10-30-1

Director

Mr.

Mr.

Mr.

Mr.

Mr.

Investment Management Corporation

None

NY 10001

Investment Management Corporation

April 22, 1968

Dear Sir:

Enclosed for you are two copies of the

Annual Report

Investment Management Corporation

Investment Management Corporation

Investment Management Corporation

James G. Collier, Treasurer

None

Mr.

CHARTERED

FOR STATE HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a medical director is necessary, please sign the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5514

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05505

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LUTHER</u> Middle <u>COOMBS</u> Last <u>COOMBS</u>		4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ODD JOBS</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN COOMBS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA STONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS. MARTHA JOHNSON, LA PLATA, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> stating the underlying cause last (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. EDLEEN</u>		DATE SIGNED <u>5-22-61</u>	
EXAMINER'S NAME (Type) <u>E. J. EDLEEN</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-27-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEWTOWN METH</u>		22d. LOCATION (City, town, or country) (State) <u>LA PLATA, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, MD</u>		24a. REC'D BY REGISTRAR <u>DAMAY 31 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>C. L. H. HARRIS</u>	

MEDICAL CERTIFICATION



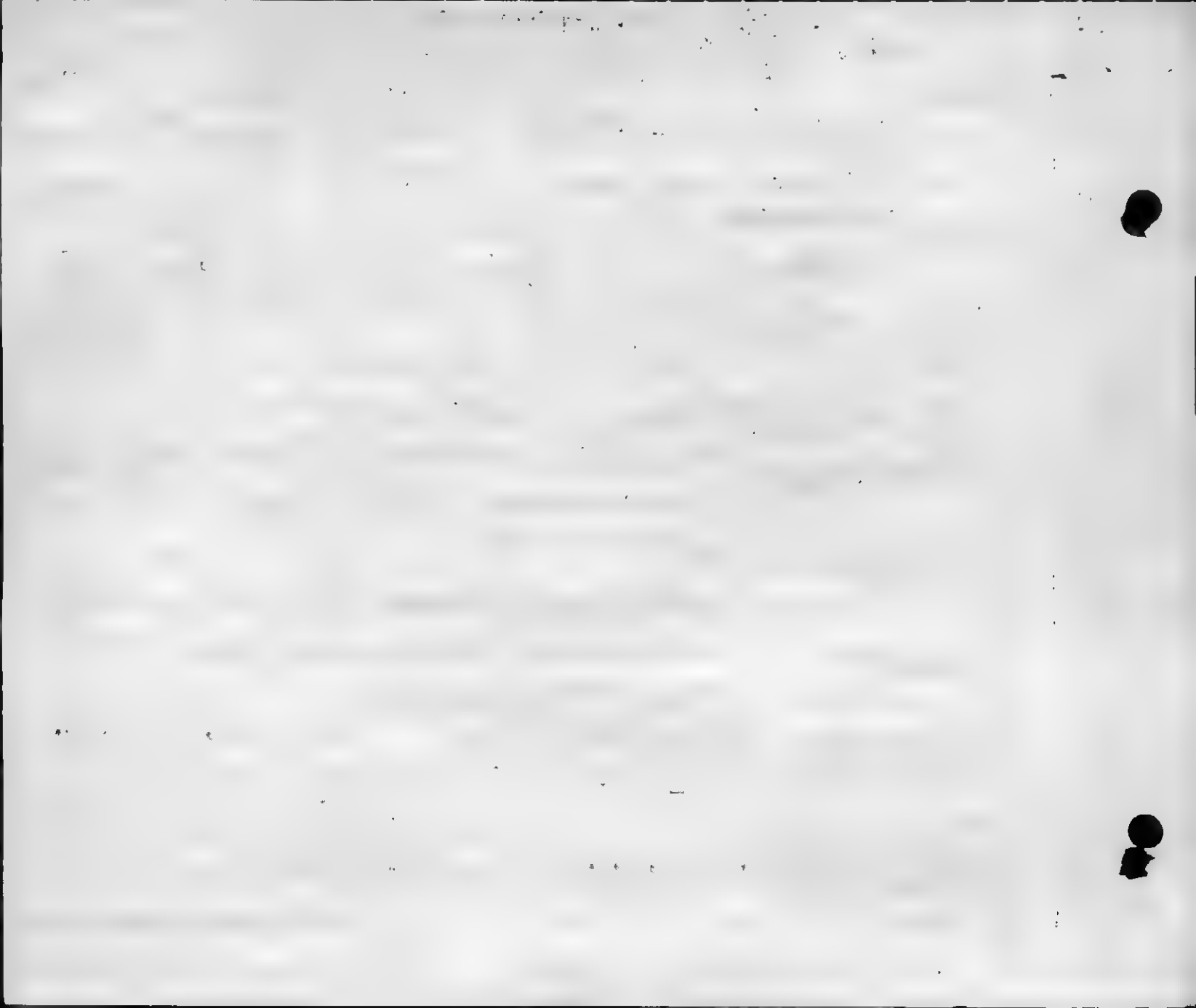
1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05506

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physician Memorial		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SAMUEL C. COOKSEY		4. DATE OF DEATH Month May Day 14 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 17, 1886
9. AGE (In years last birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME HAWKINS	
14. MOTHER'S MAIDEN NAME COOKSEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214-36-3538		17. INFORMANT Francis Walter, Hughesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Atelectasis and Left Hemothorax 102.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple fractured ribs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of window	
20c. TIME OF INJURY Month, Day, Year 3:00 PM 5/12 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Hughesville, Charles, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		DATE SIGNED 5/15/61	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER Arthur S. Knaus	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-16-61	22c. NAME OF CEMETERY OR CREMATORY MT REST	22d. LOCATION (City, town, or country) (State) LA PLATA, MD.
23. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md		24a. REC'D BY REGISTRAR MAY 17 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



5516

CERTIFICATE OF DEATH

Reg. Dist. No. 05567

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) PHYSICIANS MEMORIAL HOSP.		d. STREET ADDRESS Spring Hill	
3. NAME OF DECEASED (Type or print) Father William COOKSEY		4. DATE OF DEATH Month May Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 May 1870
9. AGE (In years last birthday) 91 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Cooksey	
14. MOTHER'S MAIDEN NAME Sussie Elizabeth Cash		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Susie Iola Barbour - La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Collyrium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last (b) Myocardial infarction DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2m 10 days 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign tumor prostate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 1951, to 15 May , 1961, that I last saw the deceased alive on 15 May , 1961, and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Coody M.D.		ADDRESS (Street, city or town, state) JARWOOD CLINIC 16 May 61.	
PHYSICIAN'S NAME (Type) ARTHUR O. COODY		LA PLATA	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/18/61	22c. NAME OF CEMETERY OR CREMATORY Trinity	22d. LOCATION (City, town, or county) (State) New Port 704
23. FUNERAL DIRECTOR'S SIGNATURE Archibald Inc La Plata Md		24a. REC'D BY REGISTRAR DATE MAY 22 '61	24b. REGISTRAR'S SIGNATURE Charles A. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



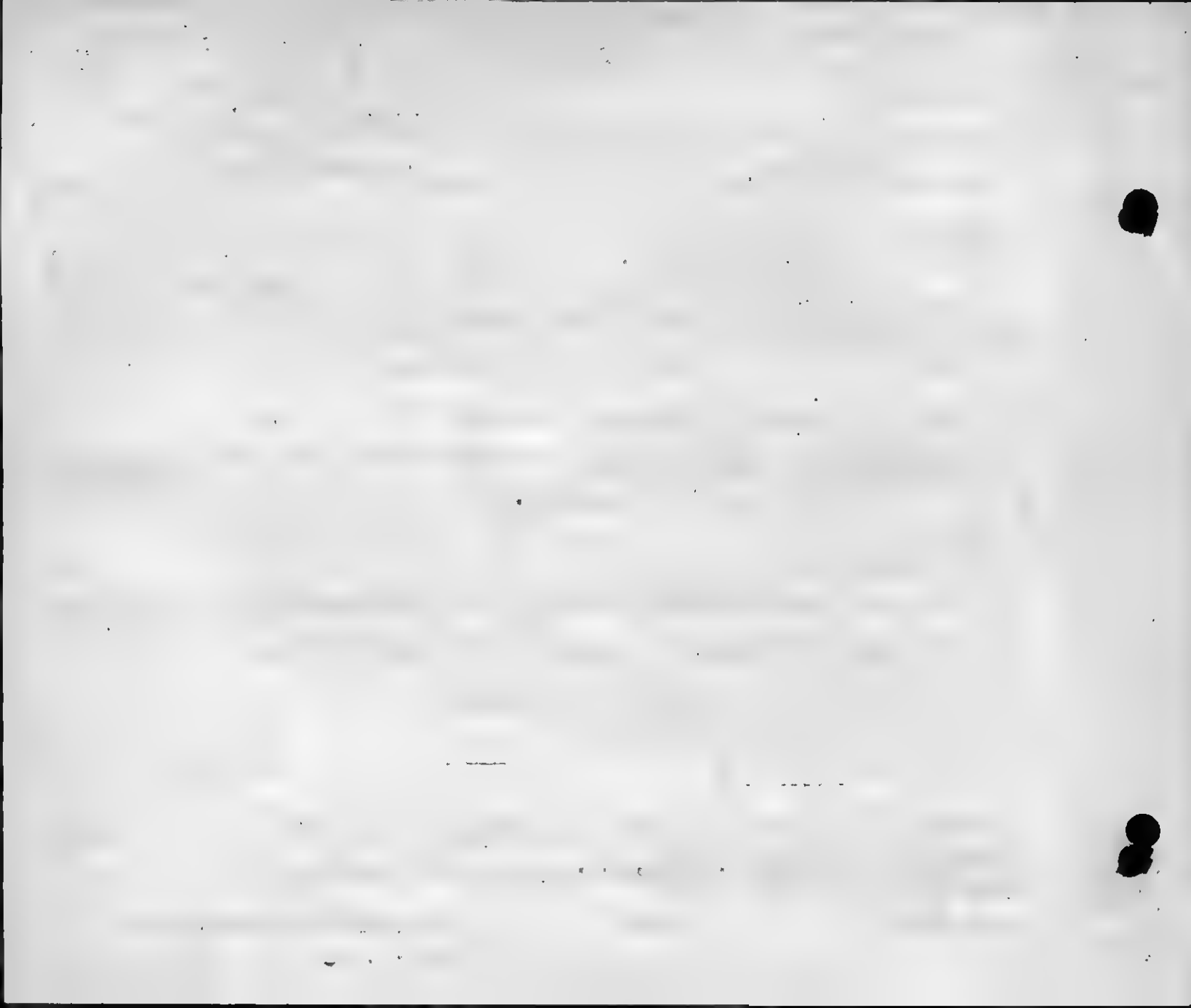
05508

M

MEDICAL CERTIFICATION

VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. ssion) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road		c. LENGTH OF STAY IN lb Bryans Road (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) KATIE		4. DATE DEATH Month May Day 16 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 29, 1909
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Ousley		14. MOTHER'S MAIDEN NAME Viola Corklile	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) No		16. SOCIAL SECURITY NO. 577-25-1400	
17. INFORMANT James Cox - Box 210 Bryans Road, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pontine H emorrhage. SSIX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 5/16/61	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/1961	22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Church Cemetery	22d. LOCATION (City, town, or country) (State) Nanjemoy, Maryland
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. - La Plata, Md.		24a. REC'D BY REGISTRAR MAY 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur E. ...			



CERTIFICATE OF DEATH

Reg. Dist. No. 5509

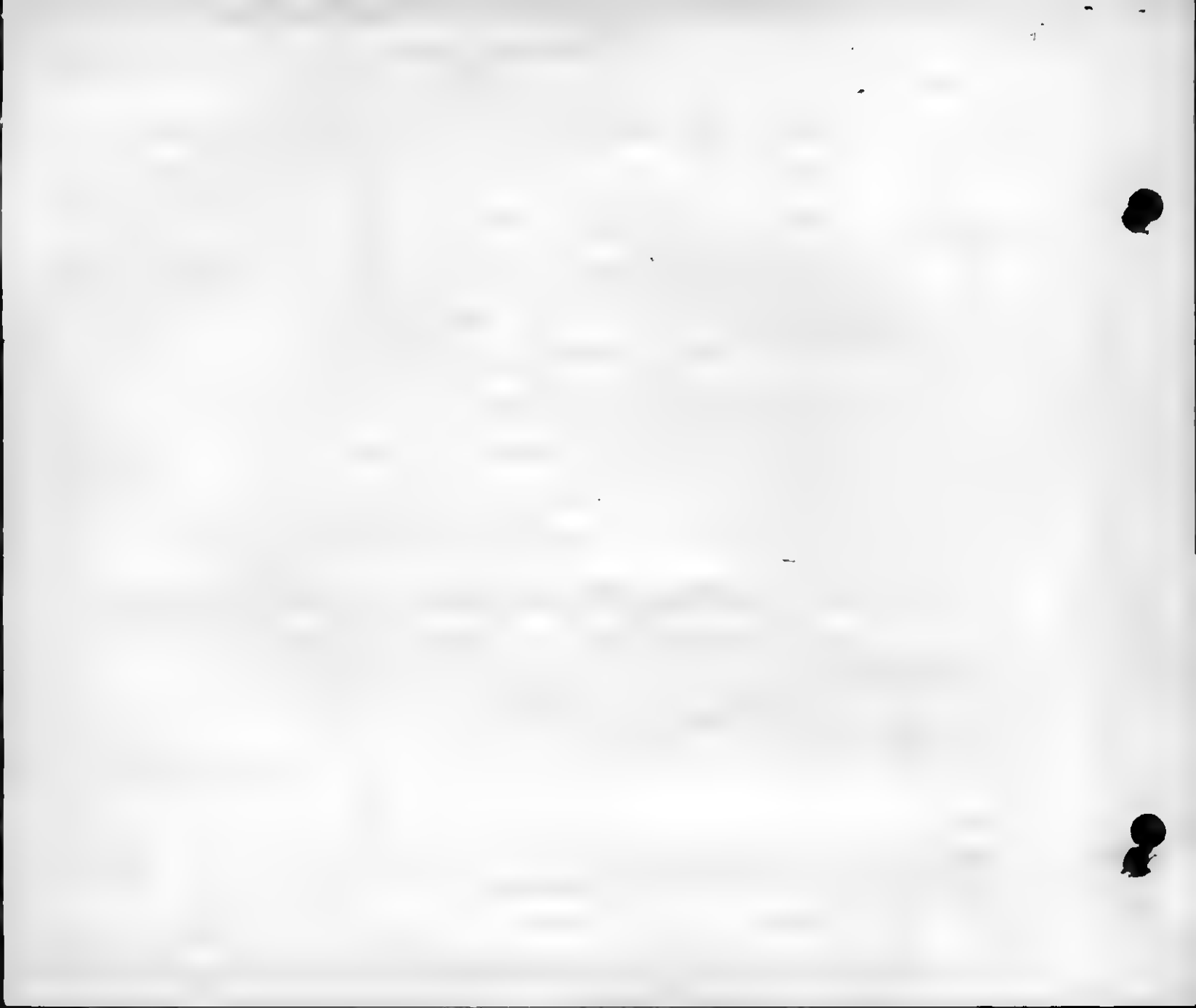
5518

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HUGHESVILLE	
c. LENGTH OF STAY IN 1b LIFE		d. STREET ADDRESS HUGHESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle DRUSCILLA Last GOOD		4. DATE OF DEATH Month MAY Day 5 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1908
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ABE GOLDSMITH		14. MOTHER'S MAIDEN NAME IDA GOLDSMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT EDWIN C. GOOD, HUGHESVILLE, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Coma 200X DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemachromatosis DUE TO (c) Hemachromatosis		INTERVAL BETWEEN ONSET AND DEATH 4 days Years 5-6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 3, 1961 , to May 5, 1961 , that I last saw the deceased alive on May 3, 1961 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE V. M. SERON MD.		ADDRESS (Street, city or town, state) Waldorf, Md	
PHYSICIAN'S NAME (Type) V. M. SERON MD.		DATE SIGNED 5/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5-8-61	22c. NAME OF CEMETERY OR CREMATORY OLD FIELDS	22d. LOCATION (City, town, or county) (State) HUGHESVILLE, MD.
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, WALDORF, MD		ADDRESS	
24a. REC'D BY REGISTRAR MAY 11 '61		24b. REGISTRAR'S SIGNATURE Charles E. Kenna	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22 Film 288
6-1-61

18-22 Film 288
6-1-61

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5519

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05510

1. PLACE OF DEATH
a. COUNTY CHARLES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mason Springs
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Star Route #2 La Plata, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mason Springs (Rural)
d. STREET ADDRESS Star Route #2 La Plata, Md.

3. NAME OF DECEASED (Type or print)
First FLORENCE Middle MAE Last GRINDER

4. DATE OF DEATH
Month May Day 22 Year 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH May 13, 1917 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Roy Hessel 14. MOTHER'S MAIDEN NAME Olive Barton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 607 - 22 - 1411 17. INFORMANT Mr. Augustus Grinder - Star Route #2 La Plata Address Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning, secondary to overingestion of intermediate-acting barbiturates
DUE TO (b) 7x1/2
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 7x1/2
DUE TO (c) 7x1/2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Found drowned in pond

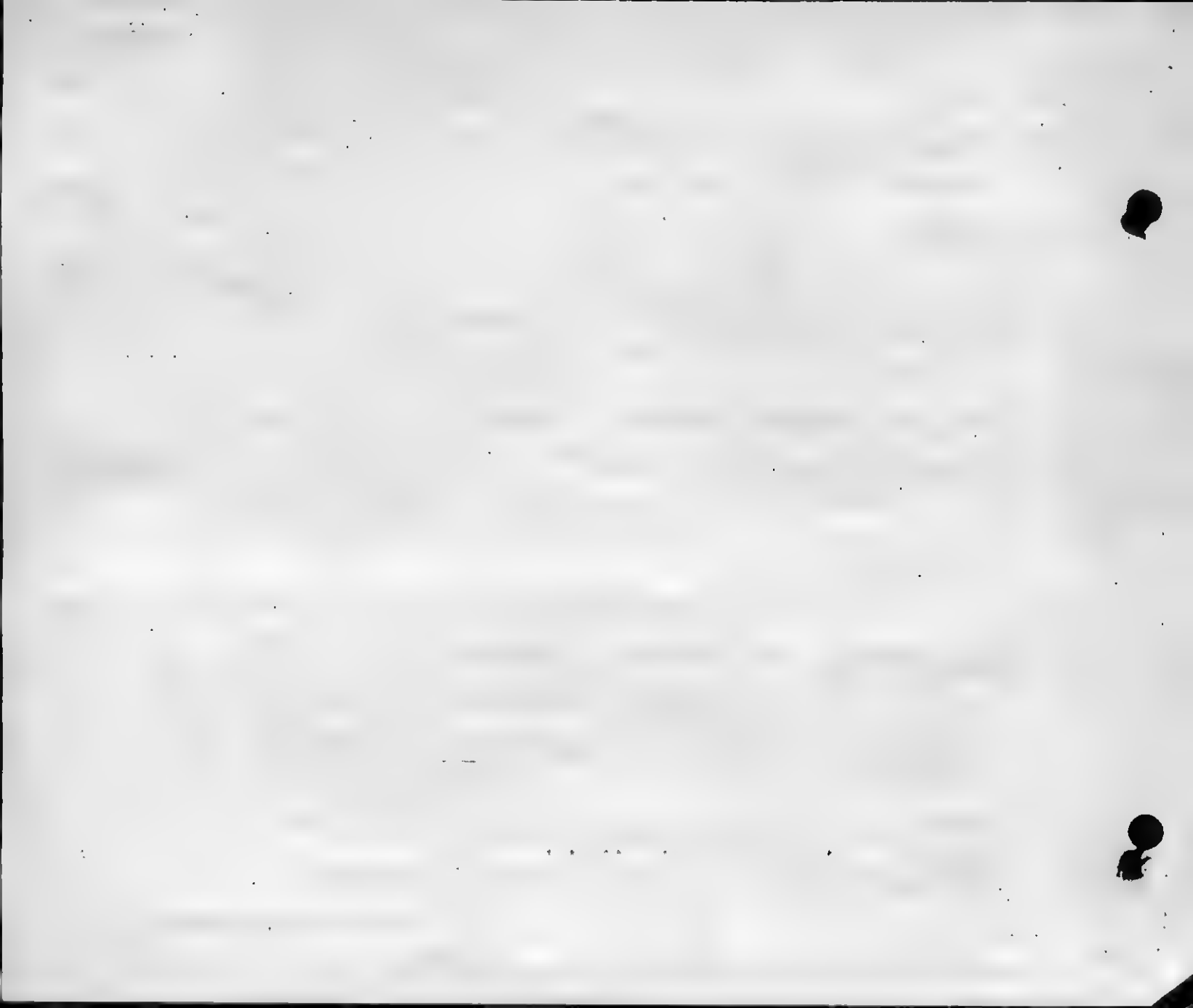
20c. TIME OF INJURY Month, Day, Year 9:30 AM 5/22/61 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond 20f. (City or town) Charles (County) Md. (State)

21 I certify that I took charge of the remains described above, held an A ☒ autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D. DATE SIGNED May 23, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/25/1961 22c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens 22d. LOCATION (City, town, or country) Waldorf, Maryland (State)

23. FUNERAL DIRECTOR Richard Funeral Home, Inc. ADDRESS La Plata, Md. 24a. REC'D BY REGISTRAR MAY 31 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Kline



CERTIFICATE OF DEATH

Reg. Dist. No.

05511

5526

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c. LENGTH OF STAY IN Tb 3-Days	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md	
f. STREET ADDRESS Old Indian Head Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nettie Hardy		4. DATE OF DEATH 5-1-61	
5. SEX Female	6. COLOR OR RACE W-US	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1884 1874
9. AGE (In years last birthday) 82 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas O. Hodges		14. MOTHER'S MAIDEN NAME Nancy Hall Pomonkey Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs Bessie Keller		Address 7-Kenwood Place Indian Head Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 721.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Disease-Cardiac DUE TO (c) Senility-Arterio Sclerosis General		INTERVAL BETWEEN ONSET AND DEATH 3-Days Indefinite Indefinite	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-10-55 , 19____, to 5-1-61 , 19____, that I last saw the deceased alive on 5-1-61 , 19____, and that death occurred at 3-50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17-Potomac Ave-Indian Head Md DATE SIGNED 5-2-61			
ACTUAL SIGNATURE James E. Andrews		M.D. 17-Potomac Ave-Indian Head Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/5/1961	22c. NAME OF CEMETERY OR CREMATORY Bunby Oak Cemetery	22d. LOCATION (City, town, or county) (State) Pomonkey, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc. La Plata, Maryland		24a. REC'D BY REGISTRAR DATE MAY 4 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

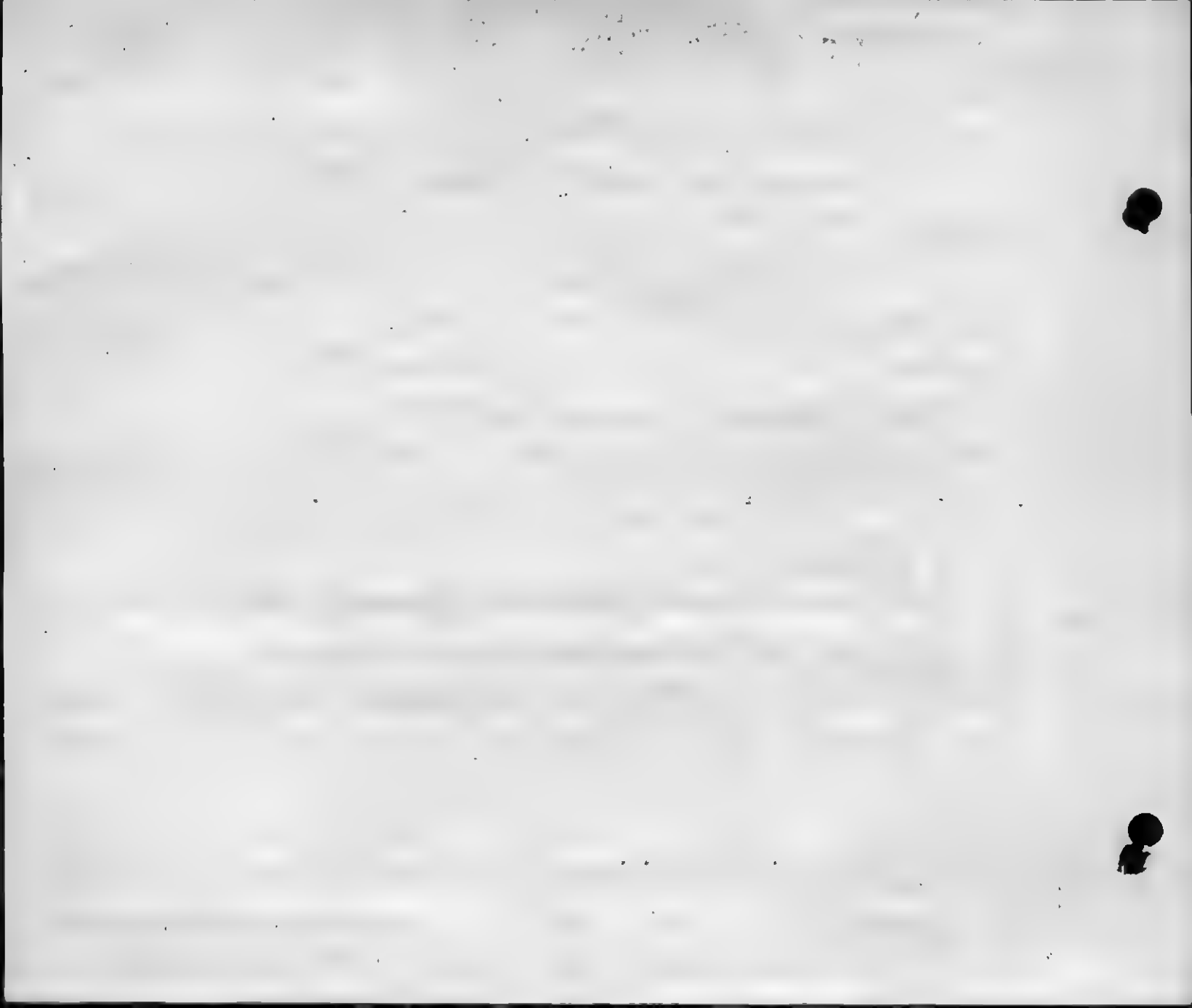
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



65512

VS. AISI
SM 9/60

1. PLACE OF DEATH a. COUNTY	Charles	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	a. STATE	MARYLAND	b. COUNTY	CHARLES		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	La Plata	c. LENGTH OF STAY IN lb	D.O.A.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Nanjemoy, (Rural)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
1d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Physicians Memorial Hospital	3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
5. SEX	Colored	6. COLOR OR RACE	Male	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	5/8/59	9. AGE (In years last birthday)	2	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Infant	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	Marbury, Maryland	12. CITIZEN OF WHAT COUNTRY?	U.S.A.	13. FATHER'S NAME	James Jennifer
13. FATHER'S NAME	James Jennifer	14. MOTHER'S MAIDEN NAME	Ruby Keys	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)	No	16. SOCIAL SECURITY NO.	None	17. INFORMANT	Mrs. Ruby Jennifer - Nanjemoy, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hemorrhagic bronchopneumonia	5/11/2	DUE TO	otitis media	CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.	(b)	DUE TO	(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20c. TIME OF INJURY	Hour	m.	p.m.	20d. INJURY OCCURRED	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	ACTUAL SIGNATURE	R. S. Fisher	M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED	5/22/61	EXAMINER'S NAME (Type)
EXAMINER'S NAME (Type)	Russell S. Fisher, M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	22b. DATE THEREOF	5/23/1961	22c. NAME OF CEMETERY OR CREMATORY	Mt. Hope Church	22d. LOCATION (City, town, or country)	Ironside, Maryland
23. FUNERAL DIRECTOR	Richard Funeral Home, Inc.	24a. REC'D BY REGISTRAR	DATE	MAY 26 '61	24b. REGISTRAR'S SIGNATURE	Charles P. C.	25. REMARKS		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the State, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

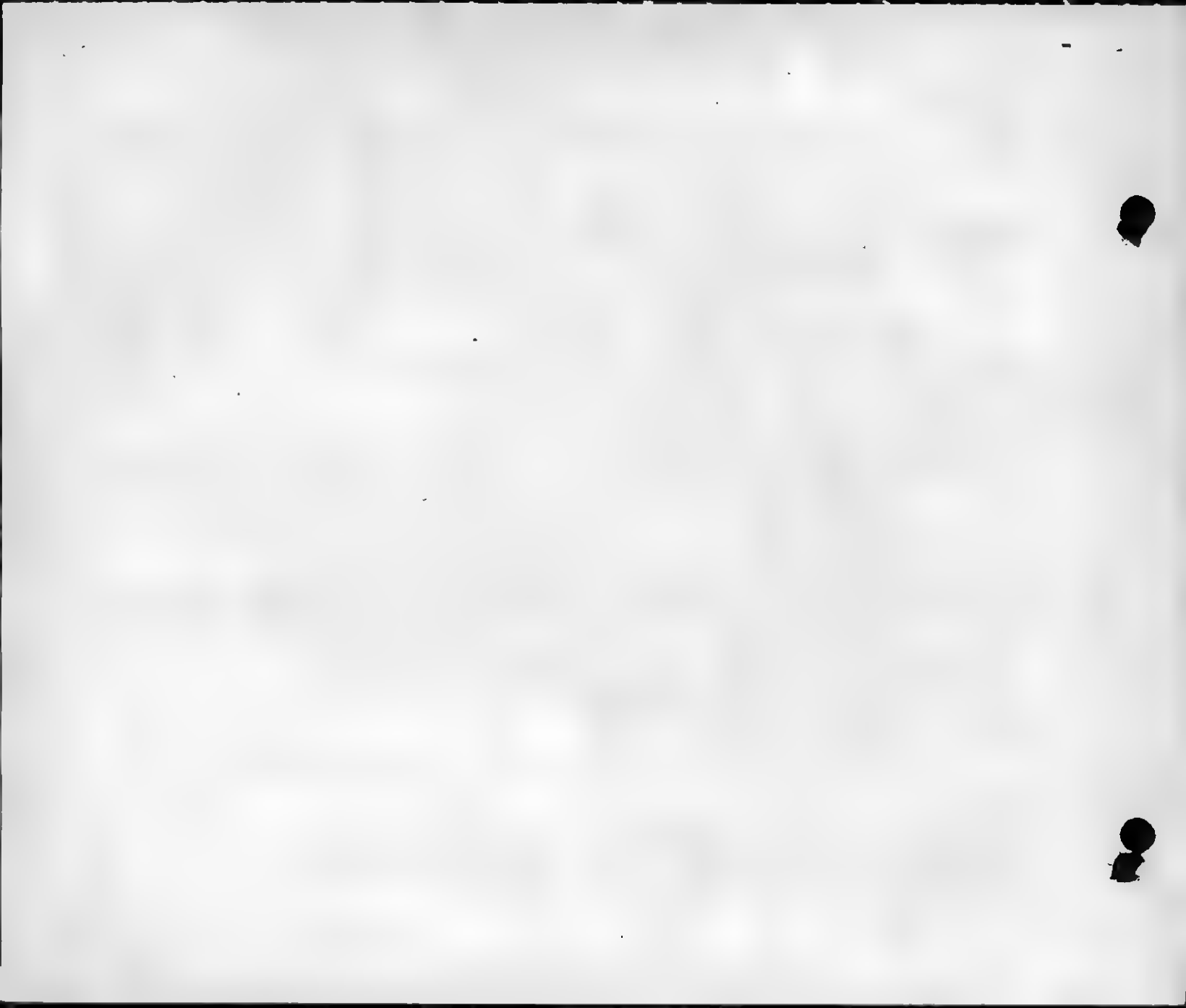
5522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>MATTHEW MADISON MUSCHETTE</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27/1916</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Anthony Muschetti</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>212-16-5255</u>	
17. INFORMANT <u>LORETTA MUSCHETTE, LA PLATA, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5-25-61</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-29-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		22d. LOCATION (City, town, or county) (State) <u>Bonifet, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wendy Funeral Home Waldorf Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank</u>	



5523

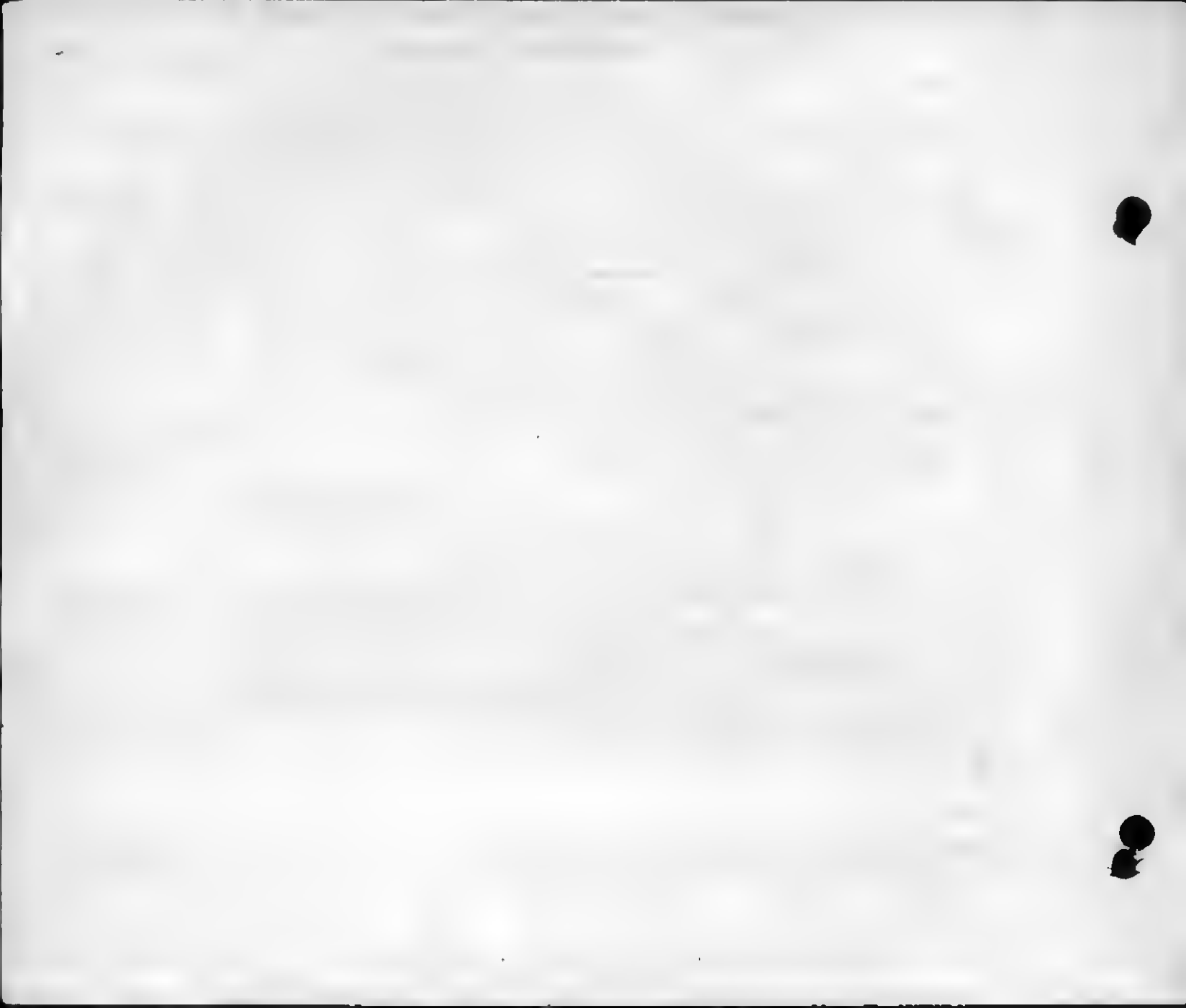
CERTIFICATE OF DEATH

Reg. Dist. No.

05514

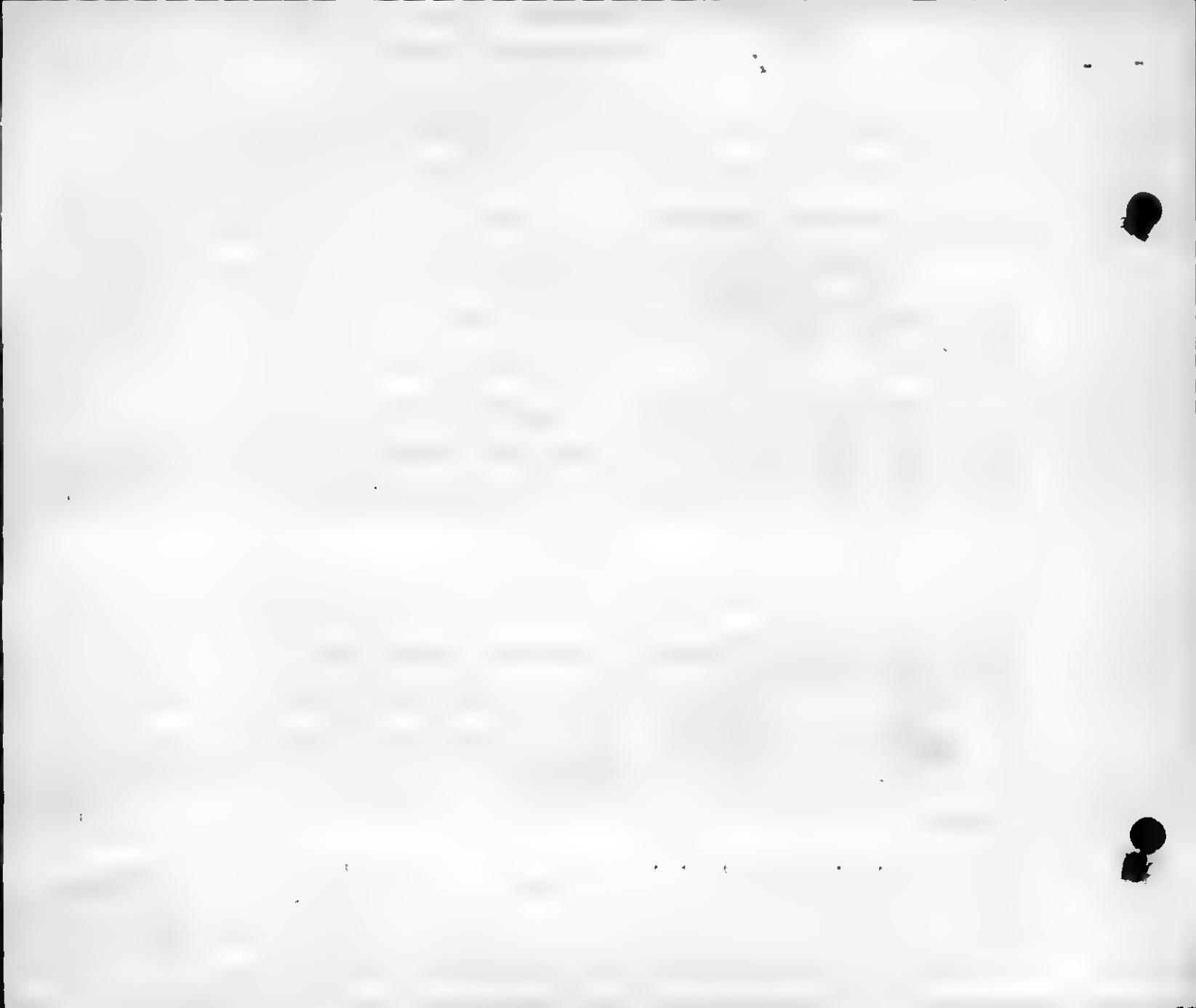
1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburgh (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) Physicans Memorial Hospital				d. STREET ADDRESS Avening Farm		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELIZABETH STODDERT REEDER				4. DATE OF DEATH Month Day Year May 20 , 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 6 , 1930		9. AGE (In years last birthday) yrs. 30	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Winchester , Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Reeder				14. MOTHER'S MAIDEN NAME Margaret Mc Cormack			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) None		17. INFORMANT Address Mr. Foster Reeder - Box #153 Newburgh , Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Massive Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN'S.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 12, 1961</u> to <u>May 20 19 61</u> , that I last saw the deceased alive on <u>May 20</u> 19 <u>61</u> , and that death occurred at <u>3:15 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>La Plata, Md</u> DATE SIGNED <u>5-20-61</u> ACTUAL SIGNATURE <u>J. Parran Jarboe</u> M.D. PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE M.D.</u> <u>La Plata , Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/1961		22c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		22d. LOCATION (City, town, or county) (State) ayside , Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archart Funeral Home, Inc.</u> ADDRESS <u>Archart Funeral Home, Inc. - La Plata , Md.</u>				24a. RECEIVED BY REGISTRAR DATE <u>MAY 26 61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 05515

MEDICAL CERTIFICATION

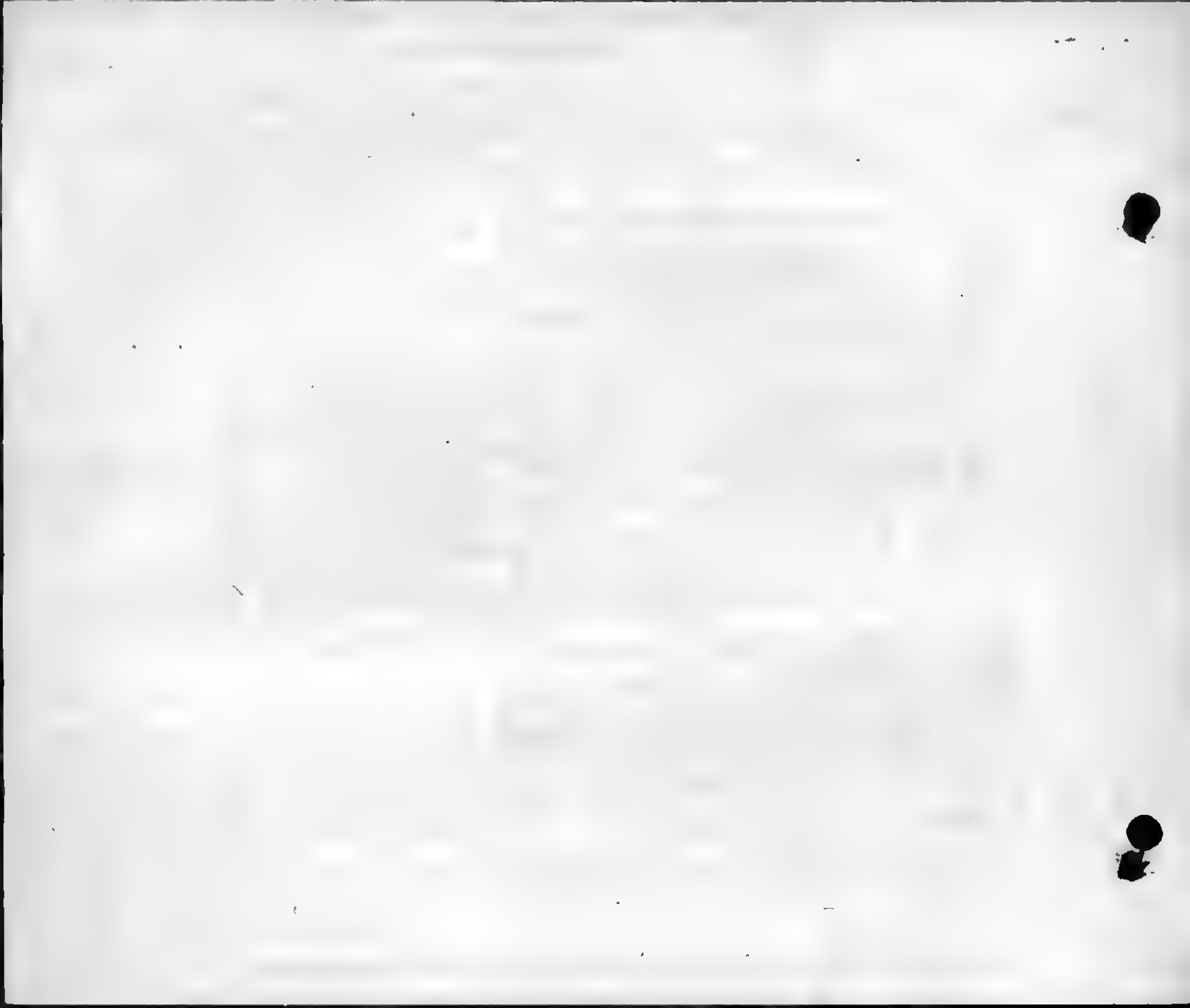


CERTIFICATE OF DEATH

Reg. Dist. No. 05516

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALTON Middle BONEVENTURE Last WADE		4. DATE OF DEATH Month May Day 18 Year 61	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1888 9. AGE (In years lost birthday) 72 yrs. IF UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FATHER		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hillary Wade		14. MOTHER'S MAIDEN NAME Martha Washington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-3351	
17. INFORMANT Alice Wade, Waldorf, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Ischemia DUE TO (c) Chronic Coronary Disease		INTERVAL BETWEEN ONSET AND DEATH 5 min 1 mo several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NO HRY-MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1961 , to May 18, 1961 , that I last saw the deceased alive on May 13, 1961 , and that death occurred at 8:20 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Waldorf, Md DATE SIGNED 5/19/61 ACTUAL SIGNATURE Vaher M. Seron M.D. Aguas NIGHT NAME (Type) VAHER M SERON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-22-61	
22c. NAME OF CEMETERY OR CREMATORY St Peters		22d. LOCATION (City, town, or county) (State) Waldorf, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Maryland		24a. REC'D BY REGISTRAR DATE MAY 23 '61	
24b. REGISTRAR'S SIGNATURE William L. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

5526

05517

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville-Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville-Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JANIE</u> Middle <u>Cecelia</u> Last <u>WADG</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Sembley</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Greenfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Ursuline Swann, Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE, RIGHT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>12 YEARS</u> <u>15 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>JULY 17, 1948</u> to <u>MAY 10, 1961</u> , that (I) had saw the deceased alive on <u>MAY 9, 1961</u> , and that death occurred at <u>10:20</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Griffin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN M.D.</u>				22d. ADDRESS <u>Hughesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		23d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. H...</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05518

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Charles Street (Route #6)		d. STREET ADDRESS Route # 6	
3. NAME OF DECEASED (Type or print) XAVIER		4. DATE OF DEATH WATTS 5 27 1961	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Watts		14. MOTHER'S MAIDEN NAME Liza Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Augustus Watts - La Plata, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED HEAD & CHEST 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hit By Two Autos (c) 5-27-61 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hit By 2 Autos - Pedestrian 20c. TIME OF INJURY Month, Day, Year 9:30 5-27-61 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) LA PLATA MD 20f. (City or town) LA PLATA (County) CHAS (State) MD		INTERVAL BETWEEN ONSET AND DEATH 5-27-61	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE E. J. EDELEN		DATE SIGNED 5-27-61	
EXAMINER'S NAME (Type) E. J. EDELEN		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/30/1961	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Church		22d. LOCATION (City, town, or country) (State) La Plata, Maryland	
23. FUNERAL DIRECTOR Archart Funeral Home, Inc. La Plata, Md.		24a. REC'D BY REGISTRAR MAY 31 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

1
FOR STATE
HEALTH DEPT.

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5528

05519

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hughesville, Md.				c. LENGTH OF STAY IN 1b Hughesville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home of Midwife, Catherine Dorsey				d. STREET ADDRESS Hughesville			
3. NAME OF DECEASED (Type or print) Infant First John Middle Francis Last Woodland				4. DATE OF DEATH Month 5 Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-'61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) yrs. 5 Months 15 Days 30		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Mason Jenifer			
14. MOTHER'S MAIDEN NAME Sarah Elizabeth Woodland				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. No				17. INFORMANT Address Catherine Dorsey, Hughesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Aspiration of Aminiotic Fluid 7620 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cried spontaneously but had blood & fluid from mouth 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mechanicsville, Md.		20g. (County) Charles		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE E. J. Edelen, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5-15-'61				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 5-15-61			
22c. NAME OF CEMETERY OR CREMATORY Family Cemetery				22d. LOCATION (City, town, or country) Mechanicsville, Md.			
23. FUNERAL DIRECTOR Hunt Funeral Home				24a. REC'D BY REGISTRAR Waldoy			
24b. REGISTRAR'S SIGNATURE Arthur L. Hunt				DATE MAY 17 '61			

4000413XV6

00513

RECEIVED



Chlorine

hydrochloric

hydrochloric acid

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric

hydrochloric